BETHESDA MEDICAL ASSOCIATES

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Bethesda, MD 20817

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Dietitian Late Cancellation / No-Show Policy and Credit Card Authorization Form

Bethesda Medical Associates is privileged to provide medical treatment for the patients of our Dieticians. We work diligently to maintain a high level of professional and personalized service, and we strive to accommodate our patient's needs in a timely manner. These objectives require careful planning and coordination among many individuals in our office.

We understand that things happen and sometimes a patient cannot appear for their scheduled appointment. If you need to cancel or reschedule an appointment, please call our office at (301) 547-0569 (no e-mails please) at least 24 hours in advance of your scheduled appointment. For Monday appointments, cancellations must be made by noon on the preceding Friday.

Our providers set aside valuable time just for you and we often maintain a wait list, which helps us see everyone who requires our services. When a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients. Therefore, in the event of a late cancellation (less than 24 hours) or no-show, we will charge your credit card for the full cost of the missed appointment. Please be aware that all fees charged by Bethesda Medical Associates pursuant to this policy are reflective of a missed business opportunity and are not reimbursable by your insurance provider. Thank you for your understanding.

Please note: BMA's receipt of this form is required to reserve your upcoming appointment. **If we have not received a completed, signed copy within 7 business days from the date you called to schedule, the appointment will be cancelled, and we will not be able to reschedule until your form is received.**

CARDHOLDER INFORMATION

Name: _____

Billing Street Address: _____

City: _____ State: _____Postal Code: _____

Telephone: _____

_____ **(Initials)** I authorize a late-cancellation charge against my credit card for the full cost of the session in the event that I cancel with less than 24-hour notice.

_____ **(Initials)** I authorize a no-show charge against my credit card for the full fee of the session in the event that I do not appear for my scheduled appointment, and I do not call to cancel with at least 24 hours' notice.

CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Card Number: _____

Expiration Month/Year: _____ Security Code: _____

Cardholder Signature: _____ Date: _____

Completed, signed forms must be submitted via e-mail (to billing@bethesdamed.com) or postal mail within **7 business days after calling us to schedule.

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